LOUISIANA DEPARTMENT OF HEALTH
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Health Standards Section
License Application
Behavioral Health Service Provider

Section 1: PROVIDER INFORMATION

☐ *INITIAL APPLICATION* ☐ *RENEWAL APPLICATION* ☐ *OTHER* (Specify) _____

LICENSE NUMBER _____ *EXPIRATION DATE* _____

**Check & Payment Transmittal Form must be submitted to LDH Licensing Fee, PO Box 62949, New Orleans, LA 70162-2949*

TOTAL FEE AMOUNT INCLUDED _____ *CHECK / MONEY ORDER #* _____

STATE ID #BH___ ___ ___ ___ ___ ___ ___

FACILITY (DBA) NAME _____

GEOGRAPHICAL ADDRESS _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (____) _____ *FAX NUMBER* (____) _____ *EMAIL ADDRESS*_____
(not voicemail)

**MAILING ADDRESS (IF DIFFERENT)* _____

CITY / STATE / ZIP _____

HOURS OF OPERATION _____

MONDAY	*TUESDAY*	*WEDNESDAY*	*THURSDAY*	*FRIDAY*	*SATURDAY*	*SUNDAY*

ADMINISTRATOR _____ **Email** _____

MEDICAL DIRECTOR _____

CLINICAL DIRECTOR (See §5643 (B)(2)) _____

Is this facility located on the campus or in the building of another healthcare facility?

☐ *No* ☐ *Yes* *If yes, list the name and state ID# of the other healthcare facility:* _____

Accredited? ☐ *No* ☐ *Yes*: *Accrediting organization:* _____ *Expiration date:* _____
If "YES" you may request for "deemed" status in writing post licensure approval (refer to the regulations)

Section 2: TYPE OF FACILITY/PROVIDER

TYPE OF SERVICE: ☐ *Substance Abuse/Addiction only** ☐ *Mental Health only* ☐ *Both**

** if checked, who is the Addictionologist?* _____ *See* §5693.

POPULATION SERVED: ☐ *Adults (18+)* ☐ *Adolescent (13-17yo)* ☐ *Children (under13)*

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-0157 • http://new.dhh.louisiana.gov/healthstandards

TYPE of facility and TREATMENT PROGRAMS:

☐ ***RESIDENTIAL FACILITY*** *(substance abuse /addiction treatment programs only)*

- ☐ ***Clinically Managed Low-Intensity Residential Treatment Program (Halfway House) (ASAM Level III.1)***
- ☐ ***Clinically Managed Medium-Intensity Residential Treatment Program (adult only ASAM Level III.3)***
- ☐ ***Clinically Managed High-Intensity Residential Treatment Program (ASAM Level III.5)***
- ☐ ***Clinically Managed Residential Detoxification Program (Social Detoxification ASAM Level III.2D)***
- ☐ ***Medically Monitored Intensive Residential Treatment Program (adult only ASAM Level III.7)***
- ☐ ***Medically Managed Residential Detoxification (Medically Supported Detoxification- adult only- ASAM Level III.7D)***
- ☐ ***Mothers with Dependent Children Program (Dependent Care Program)***

NUMBER OF LICENSED UNITS (Bedrooms) _____ ***NUMBER OF LICENSED BEDS*** _____

☐ **OUTPATIENT FACILITY**

- ☐ ***Mental Health Services Program/ Clinic***
- ☐ ***Psychosocial Rehabilitation Services Program***
- ☐ ***Crisis Intervention Program***
- ☐ ***Community Psychiatric Support and Treatment Program***
- ☐ ***Addiction Outpatient Treatment Program (ASAM Level I)***
- ☐ ***Ambulatory Detoxification with Extended on-site monitoring Program (ASAM Level II-D)***
- ☐ ***Intensive Outpatient Treatment Program (ASAM Level II.1)***
- ☐ ***Partial Hospitalization (ASAM Level II.5) See §5698***
- ☐ ***Opioid Treatment Program (if approved by SOTA)***

☐ **HOME and/or COMMUNITY SERVICES PROGRAM** *(seen in the home and /or community only; **never** in the office)*

- ☐ ***Psychosocial Rehabilitation Services Program***
- ☐ ***Crisis Intervention Program***
- ☐ ***Community Psychiatric Support and Treatment Program***

Section 3: TYPE OF OWNERSHIP

NON- PROFIT	FOR – PROFIT	GOVERNMENT
☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *FEDERAL* ☐ *HUMAN SVCS DISTRICT/ AUTHORITY*
☐ *CORPORATION* ☐ *LLC*	☐ *CORPORATION* ☐ *RELIGIOUS AFFILIATION*	☐ *CITY*
☐ *PARTNERSHIP*	☐ *PARTNERSHIP*	☐ *CITY/PARISH*
☐ *RELIGIOUS AFFILIATION*	☐ *GROUP PRACTICE* ☐ *UNINCORPORATED ASSOCIATION*	☐ *HOSPITAL DISTRICT*
☐ *UNINCORPORATED ASSOCIATION*	☐ *LLC*	☐ *COMBINATION GOV-N-PROFIT*
☐ *OTHER (Specify):* _____	☐ *OTHER (Specify):* _____	☐ *OTHER (Specify)* _____

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BEHAVIORAL HEALTH SERVICE PROVIDER LICENSE APPLICATION

LEGAL ENTITY / CORPORATION NAME _____ *EIN#* _____

ADDRESS _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (_____) _____ *FAX NUMBER (_____)* _____

If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	*ADDRESS*	*TELEPHONE NUMBER*

Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ *Yes* ☐ *No*
(Proprietorship, Partnership or Board Member) If yes, list names, addresses of individuals and other providers.

Owner	*Facility Name*	*Facility Address*	*Provider #, LIC.#, or State ID#*

Has there been a change of ownership or control within the last year? ☐ *Yes* ☐ *No* *If yes, give date:*_____

Section 4: OFF-SITE INFORMATION *(attach addendum A's for each offsite listed below)*

INDICATE THE NAME, ADDRESS, CITY, STATE, ZIP, PARISH, AND TELEPHONE NUMBER OF EACH OFF-SITE CAMPUS

OFF-SITE NAME	*GEOGRAPHICAL ADDRESS* (Street, City, State, & Zip Code)	*PARISH*	*TELEPHONE NUMBER*	*LICENSE NUMBER*
1.				
2.				
3.				
4.				

Section 5: ATTESTATION & SIGNATURE

***ATTESTATION** (Read carefully):*
I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

_____
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

_____ _____
AUTHORIZED REPRESENTATIVE SIGNATURE *DATE*

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OFF-SITE ADDENDUM A

OFF-SITE NAME	*LICENSE #*	*ADDRESS OF OFFSITE*	*PARISH*	*TELEPHONE NUMBER*

************See §5605.(G.) regarding Off-Sites *************

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********Make copies of this addendum as needed for each offsite*********

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